Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #: M4-09-7312-01
ADVANCED PRACTICE INC. FOR TEXAS INSTITUTE FOR SURGERY 17101 PRESTON ROAD SUITE 180-S DALLAS TEXAS 75248	
Respondent Name and Box #: FEDEX FREIGHT INC REP BOX #: 19	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "…The carrier, Cambridge Integrated Services Group Inc., has denied reimbursement at the contracted state fee guideline for this Worker's Compensation Claim…the hospital fee guideline published by the Department of Workers Compensation (DWC)…states that *the reimbursement calculation shall be the Medicare facility-specific amount multiplied by 200%.* …It appears the carrier reimbursed Revenue Code 360 with CPT code 24342 at 100% of billed charges…Reimbursement is to be at 200% of the Medicare facility specific rate…"

Principle Documentation:

1. DWC 60 package
2. Hospital or Medical Bill(s)
3. EOB(s)
4. Medical Reports
5. Total Amount Sought $1,746.39

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "…The billing in dispute has been paid at a fair and reasonable rate in accordance with the DWC guidelines, policies and rules and the Texas Labor Code. Carrier has determined that $3658.75 represents an amount greater than or equal to the fair and reasonable reimbursement for this service…Carrier has calculated reimbursement based on a fair and reasonable standard…"

Principle Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Services in Dispute	MAR Calculation	Amount in Dispute	Amount Due
07/07/2008	Hospital Outpatient Services CPT code 24342	$2,702.74 (APC) + $0.00 (Fee Schedule) + $0.00 (Outlier Amount) = $2,702.74 (OPPS) x 200% = $5,405.48 - $3,658.75 (Total paid by Respondent) = $1,746.73.	$1,746.39	$1,746.39
			Total Due:	$1,746.39

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule §134.403, titled ***Hospital Facility Fee Guideline – Outpatient,*** effective for medical services provided in an outpatient acute care hospital on or after March 1, 2008, set out the reimbursement guidelines for Hospital outpatient services.

This dispute was filed in the form and manner as prescribed by 28 TAC §133.307 and is eligible for Medical Dispute Resolution under 28 TAC §133.305 (a)(4).

1. The services listed in Part IV of this decision were denied or reduced by the Respondent with the following reason codes:
   Explanation of benefits with the listed date of audit 08/14/2008
   - L002 — The reimbursement amount is based on the Medicare reimbursement plus the percentage increase specified by the state.

   Explanation of benefits with the listed date of audit 02/16/2009
   - W1 (855-002) — Workers Compensation State Fee Schedule Adjustment. Recommended allowance is in accordance with Workers Compensation Medical Fee Schedule Guidelines. $3,658.75.
   - ** — No additional allowance is recommended.

2. Rule 134.403 (e) states in pertinent part, "Regardless of billed amount, reimbursement shall be:

   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or

   (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables;…"

3. Pursuant to Rule 134.403(f), "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register*. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 200 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

4. Under the Medicare Outpatient Prospective Payment System (OPPS), all services paid under OPPS are classified into groups called Ambulatory Payment Classifications or APCs. Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC for an encounter. Within each APC, payment for ancillary and supportive items and services is packaged into payment for the primary independent service. Separate payments are not made for a packaged service, which is considered an integral part of another service that is paid under OPPS. An OPPS payment status indicator is assigned to every HCPCS code. Status codes are proposed and finalized by Medicare periodically. The status indicator for each HCPCS codes is shown in OPPS Addendum B which is publicly available through the Centers for Medicare and Medicaid services. A full list of status indicators and their definitions is published in Addendum D1 of the OPPS proposed and final rules each year which is also publicly available through the Centers for Medicare and Medicaid services

5. In reference to disputed code 62311, the payment status indicator is T. T is defined as "Paid under OPPS; separate APC payment. Outpatient significant procedures subject to multiple procedure discounting. The highest payment Status T APC is paid at 100%; all others are paid at 50%." It is for this reason that additional payment is recommended for the disputed service.

6. Upon review of the documentation submitted by the requestor and respondent, the Division finds that:

   (1) No contract exists;

   (2) MAR can be established for these services; and

   (3) Separate reimbursement for implantables was *NOT* requested by the requestor.

7. Consequently, reimbursement will be calculated in accordance with Rule §134.403 (f)(1)(A) as follows:

APC Value	Fee Sch	Outlier Payment	Separate Reimbursement for implantables WAS NOT requested under Rule §134.403	APC + Fee Schedule + Outlier Payment X 200%	Subtract Amount Paid by Respondent	Results in additional Amount Due to Requestor
$2,702.74	$0.00	$0.00	$0.00	$5,405.48	$3,656.75	$1,746.39

8. Based upon the documentation submitted by the parties and in accordance with Texas Labor Code Sec. 413.031 (c), the Division concludes that the requestor, Advanced Practice, Inc., on behalf of Texas Institute for Surgery, is due additional payment. As a result, the amount ordered is $1,746.39.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
28 TAC Rule §134.403
28 TAC Rule §133.307
28 TAC Rule §133.305

PART VII: DIVISION DECISION

The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,746.39 plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature	Medical Fee Dispute Resolution Officer	September 28, 2009 Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.